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**What is a Current Procedural Terminology (CPT) code?**

A CPT code is a unique code that identifies a specific physician service for payment. CPT codes are developed and maintained by the American Medical Association (AMA) CPT Editorial Panel.

**What is the Resource Based Relative Value Scale (RBRVS), the RBRVS Update Committee (RUC) and the Relative Value Unit (RVU)?**

The RBRVS is the methodology used by the AMA RUC to assign RVU's to CPT codes. This is essentially the methodology (RBRVS), committee (RUC) and resulting reimbursement value (RVU) that is attached to each CPT code to determine how much the Centers for Medicare and Medicaid Services (CMS) will pay for each medical service as defined by a CPT code.

**What factors are considered by the RUC when determining a RVU for each CPT code?**

Per the ABR NIS study guide, RVUs are supposed to reflect the work RVU (time, intensity, effort, and skill required to accomplish a physician service), practice expense RVU (costs of practice maintenance including non-physician staff, supplies, equipment), and the malpractice RVU (cost of professional liability expenses). Additionally, there are geographic cost adjustments put into an annual Conversion Factor that determines the final CMS payments that are listed in the Medicare Physician Fee Schedule.

Note that the work RVU is often used as a metric of physician productivity so if you hear something like (partners are expected to have ___ RVUs/year they are referring to the work RVUs that a physician generates.

Technically, CMS assigns RVUs to services on an independent basis, but per the ABR NIS study guide, the AMA RUC recommendations are accepted by CMS in more than 90% of cases.

**Per the ABR NIS study guide, CMS and private insurers generally pay only for services deemed medically necessary. What is the CMS definition for medical necessity?**

Per the ABR NIS study guide, the definition of medical necessity used by CMS is "healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."

Medical necessity is determined at the time a claim is submitted to a payer, and part of this determination is ensuring that a CPT service code matches a pre-approved diagnosis code list. See the next question.

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### What is the International Classification of Diseases (ICD) system and who establishes this system?

The ICD system is established by the World Health Organization and comprises the diagnosis codes for which a CPT service code must match in order to determine medical necessity. The current version of ICD is ICD-10. ICD codes describe the signs, symptoms, or specific diagnosis of a patient that then form the indication for a healthcare service.

The ABR NIS study guide specifically points out that in documentation, terms such as "rule out" or "consistent with" are not sufficient to assign an ICD-10 code and do not meet medical necessity criteria. Therefore, for radiology services a symptom such as "chest pain" may be appropriate to attach an ICD code but "rule out pneumonia" would not be appropriate as justification of assigning an ICD code.

My summary of CPT and ICD codes for a radiologist is as follows: CPT codes identify the physician service performed, such as performing and interpreting an x-ray or CT scan. ICD codes identify the patient sign, symptom, or diagnosis that justifies the service identified by the CPT code.

### How are IDC-10 and CPT codes actually assigned for a given radiology service?

Professional coders, with the aid of software tools, evaluate documentation in healthcare records/physician reports to extract information to assign ICD-10 and CPT codes. Coders must be credentialed by the Radiology Coding Certification Board. Coders principally use statements about exam indications and clinical history from the referring physician and/or patient and diagnostic information from the findings or (best) impression of the radiology report to assign appropriate ICD-10 codes. To assign CPT codes, coders look at specific details of the described service.

### What are some factors from radiology services that are considered when assigning "complexity" for CPT codes?

Basically, the more complex an exam, the higher complexity can be assigned to a CPT code. The rationale is that some services are more complex than others, for example some x-rays may have many more views that need to be performed and interpreted compared to others and some ultrasound studies evaluate more organs/structures/features than others, therefore reimbursement may vary between these services. The ABR NIS study guides states that for x-rays, more views generally mean higher complexity codes, for ultrasound, "inventory 'checklists'" exist that determine complexity, for CT and MRI details of contrast administration determine the CPT complexity code level for a specific body part. The ABR NIS study guide states that structured template reporting helps radiologists comply with many of these reporting requirements to aid appropriate reimbursement and regulatory compliance.

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### What are radiology benefit management (RBM) companies?

Per the ABR NIS study guide, many private payers, Medicaid plans, and Medicare Advantage plans contract with RBM companies and require preauthorization (aka precertification) as a condition for reimbursement of elective outpatient advanced imaging services. This preauthorization is something that may be required to obtain before performing advanced imaging services which may include CT, MRI and PET/CT scans. The ABR NIS study guide states that radiology facilities should determine whether preauthorization is required for a specific service for a specific patient and, if so, whether this preauthorization has been obtained. Furthermore, the ABR NIS study guide states that although a necessary condition for payment, obtaining preauthorization by an RBM does not necessarily guarantee that medical necessity will be determined by the insurer when the claim is filed.

Importantly, you should know that preauthorization requirements generally do not apply to inpatient and emergency department services.

### What is the False Claims Act (FCA) and how can radiology practices be compliant with the FCA?

The FCA protects the government from being overcharged or sold substandard goods or services. Basically, a false claim refers to fraudulent claims wherein payment is requested for services that a provider knew were false or fraudulent. The U.S. Department of Justice expects physicians and radiology practices to have processes, structures, and cultures oriented toward integrity of revenue cycle operations/billing. The best practice is to have a formal compliance plan, with a formally appointed compliance officer and compliance committee to oversee revenue operations.

### What are penalties that can be enacted for not complying with the FCA?

Penalties from a false claim ruling can include fines up to 3x the billed amount plus $11,000 per claim filed. A single exam or service billed to Medicare or Medicaid counts as a single claim. The ABR NIS study guide states that to date, the largest settlement agreement by a radiology practice for being in violation of the FCA is $7 million US dollars.